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The Canada Health Act: *Facts and Fallacies*

by Kieran A.G. Bridge

There are many myths and misunderstandings surrounding the health care and health insurance systems in this country. Very often, articles and commentaries that are presented as "informed" actually perpetuate these misunderstandings. At times they only misinform readers about fundamental aspects of these systems, their legal bases, and how they operate.

Nowhere is this more common than in discussions about the Canada Health Act (CHA). The CHA is in fact very limited in scope. To appreciate how the CHA operates, it is important to note two things: (1) there is a vital difference between health *care* and health *insurance*, and (2) the federal government has virtually no constitutional jurisdiction over either of these matters.

This article is intended to dispel some of these myths and misunderstandings.

Health *care* is the provision of medical services. Health *insurance* pays for those services. In Canada, many of these services are provided in public hospitals[1] and by provincially-employed staff. However, a large proportion of health care is provided in privately-owned clinics and other facilities. In fact, most doctors' offices and many other medical facilities in Canada are privately-owned and operated as businesses, even though much of their revenue comes from provincial governments' medical insurance plans.

One of the more prevalent myths is that the CHA requires that hospitals be government-owned and operated and prohibits privately-owned medical facilities. This fallacy is the touchstone of many who oppose private clinics on the basis that they are "violations of the Canada Health Act." In fact, the CHA says nothing about how, or where, health care is delivered. The CHA also does not require, or even mention, public ownership of medical facilities or public employment of doctors or other health care providers. Suggestions that private clinics or privately employed doctors and nurses amount to "violations" of the CHA are simply wrong.

The CHA is nothing more than a funding law. It governs, on rather loose terms, the transfer of money from the federal government to the provinces to subsidize the cost of provincial governments' health insurance plans. The CHA has been described by courts as an exercise of the federal government's "spending power" under the constitution.

It is also important to note that the federal government has no jurisdiction to make laws banning private health insurance, for example, or governing privately-owned medical facilities. Those are provincial matters under the constitution.[2] The CHA does not purport to control what individuals or businesses can or cannot do. It is therefore impossible for any citizen or business to "violate" the CHA. In fact, even provinces cannot be taken to court successfully for breaching the CHA. Courts have consistently held that they cannot rule on whether a province has complied with the CHA. Courts have held this is a political rather than a legal matter, and that the ramifications of non-compliance with the CHA must be determined by the federal cabinet and Minister of Health, by possibly withholding cash transfers to a province.

Every province has a taxpayer-funded health insurance plan. Provincial insurance plans are government-run systems that receive money from taxpayers, through premiums, or allocation of government revenue, or both. As a matter of constitutional law, provinces may pass any laws they want about whether there is any government medical insurance and, if so, what its limits are. The coverage under existing government plans is far from comprehensive. Two major gaps that are largely filled by private insurance are the costs of most dental care and medications. About 30 percent of health care costs in Canada are currently paid for by private insurance or directly by patients.

Most, but not all, provinces have laws that ban private medical insurance for services that are covered by government insurance plans. This is because of con-

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ditions that the federal government attaches to its contribution to the cost of health care. Since the late 1950s, the federal government has contributed to medical costs through financial transfers to the provinces. This culminated in the passing of the CHA in 1984. At that time the contribution of the federal government to taxpayer-funded medical costs was about 50 percent of the national total. Currently the contribution is about half that. Clearly, the level of federal financing that provided the political backdrop to the creation of the CHA no longer exists.

Despite this, the federal government continues to tie the provinces' hands by attaching conditions to its financial transfers. Under the CHA, for a province to receive a "full cash contribution" from the federal government, the province's health insurance plan must meet several criteria, including "public administration" and "comprehensiveness." "Public administration" is defined to mean that the provincial health *insurance* plan (*not* the provision of medical care) must be administered on a non-profit basis by a public authority. "Comprehensiveness" is not clearly defined. There is no national standard of what services must be covered by provincial insurance plans.

The CHA also says extra-billing and user charges must not be permitted by a province, or else funding from the federal government may be reduced. "Extra-billing" is charging a patient an amount above what is paid under the province's health insurance plan. "User charges" are any charges by care providers for provincially-insured services. In other insurance contexts, user charges are called "deductibles" and are intended to encourage safety and reduce claims. Imagine if automobile insurers were prohibited from selling collision insurance with a deductible; both the number of claims and the frequency of small claims would skyrocket.

The prohibition of government health insurance deductibles under the CHA does nothing to encourage Canadians to take care of their health, or to promote judicious use of health care facilities and services. This largely explains why health care costs are the biggest single component of provincial budgets. Various analysts have projected those costs will consume between 50 and 70 percent of British Columbia's total annual budget within 10 years. The situation is similar in other provinces as the population ages and treatment becomes more expensive. Such government expenditures are obviously not sustainable. This fact alone makes more reliance on private medical insurance inevitable.

Despite the increasing financial burden that provincial health insurance plans face, where any of the criteria in the CHA are not met by a province, the federal cabinet "may" withhold some or all of the federal cash contribution. Where user fees and extra-billing occur, the federal minister of health "shall" deduct from the federal cash contribution the estimated amount of the user charges or extra-billing.

Some provinces are looking to reduce the cost of provincially-insured medical care by using more efficient, lower cost care providers than those in government-operated facilities. Provinces are able, under the constitution, to pass laws about whether, and to what extent, medical facilities are owned, and health care workers are employed, by government. The CHA does not address this.

The political debate on reforming this system has become interminable. In 2005, the Supreme Court of Canada recognized this government inaction in the *Chaoulli* decision when it acknowledged that citizens have been forced to turn to the courts for relief because governments have failed to provide solutions to growing wait lists. The court also recognized that provinces use wait lists as a rationing system to reduce spending by government health insurance plans.

These facts indicate that more efficient provision of medical care will be necessary in the foreseeable future, and that provincial governments' insurance plans will not be able to afford the growing demand for health care without increasing supplements from private payers. As these realities take hold, the political will to maintain the restrictions in the CHA that stifle effective reform is likely to wane, as will be the willingness and—perhaps even more significantly—the financial ability of provinces to maintain restrictions on private medical insurance. In any event, if governments maintain those restrictions while continuing to fail to pay for or provide timely care, the courts will probably decide the matter for them, on behalf of adversely affected citizens.

Notes

[1]Although Canadian hospitals are legally considered private, not-for-profit entities, they are governed largely by a political process, given wage schedules for staff, are told when investment can be undertaken, denied the ability to borrow privately for investment, told which investments will be funded for operation, and forcibly merged or closed by provincial governments. Thus, they should be considered public hospitals.

[2]In a 2006 paper entitled *Restoring Fiscal Balance in Canada,* the federal government has clearly acknowledged that health care is an exclusive area of provincial jurisdiction.

Reference

Department of Finance Canada (2006). *Restoring Fiscal Balance in Canada (Budget 2006).* Digital document available at *www.fin.gc.ca/budtoce/2006/budliste.htm.*